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ABSTRACT

This survey is one of a series conducted by The Drug Abuse Council, Inc. to explain the efforts of the public sector to control and prevent drug abuse. The survey attempts to document the involvement of the states in drug abuse prevention, treatment and control by undertaking a census of existing programs and expenditures, as well as a review of unmet problems and needs. The analysis contains survey results for all states, with size and geographic breakdowns whenever appropriate. The results are organized by responses to questions in the following areas: state administration and coordination, funding, data and epidemiology, treatment and rehabilitation, education and prevention, law enforcement, and technical assistance from the federal government. The report includes an analysis of the possible problems developing in efforts by the states to respond to drug abuse. (Author/SJL)

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SURVEY OF

STATE DRUG ABUSE ACTIVITIES:

1972

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1972



THE DRUG ABUSE COUNCIL, INC.

MS-2

MAY, 1973

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FOREWORD

The Drug Abuse Council, Inc. is a private, tax-exempt foundation which was established in February, 1972 to serve on a national level as an independent source of needed research, public policy evaluation and program guidance in the areas of drug use and misuse. It is supported by the Ford Foundation, Commonwealth Fund, Carnegie Corporation, Henry J. Kaiser Family Foundation and the Equitable Life Assurance Society of the U.S.

Through its publications and other activities, the Council hopes to provide non-partisan, objective information and analysis and serve as a resource for those organizations and individuals searching for new, more effective approaches to non-medical drug use in our society. For a complete publications list, please refer to the back of this report.

SURVEY OF STATE DRUG ABUSE ACTIVITIES 1972 is one of a series examining the efforts of the public sector to control and prevent drug abuse. A similar survey of city and county drug abuse control efforts is currently being analyzed by the Council's staff and will be published in the summer of 1973. In December of last year, The Council published **FEDERAL DRUG ABUSE PROGRAMS**, a lengthy compendium and analytic description of federal efforts through July, 1972. This was circulated to public officials and interested private citizens as a working document for substantive response.

The state survey reports data never before reviewed on this broad level. With only few exceptions, the involvement of the states in drug abuse prevention, treatment and control has been poorly documented. This lack of crucial information becomes even more important considering the power and authority invested in the states by recent federal legislation.

The Drug Abuse Council intends that this survey will facilitate the exchange of such needed informa-

tion. State officials can compare their jurisdiction's activities with the overall response, and particularly to states in their region and to states of comparable size. Federal legislation encourages increased cooperation and coordination of city and state efforts. The state survey can be used by city officials to reinforce or adjust their perceptions of present state activities. The forthcoming city/county survey can be used similarly by state officials. Federal officials will note from the analyses that a typology of the average state does not emerge. The differences that are apparent may assist these officials in formulating more flexible policies and procedures.

Only the major components and directions of state activities in drug abuse are reported in the survey. Moreover, in most cases, data was analyzed only where the number of specific responses was high enough to make such work useful. The Council staff welcomes inquiries from state or other public agencies concerning specific survey findings insofar as the confidentiality of individual responses is not jeopardized.

No survey with a response rate exceeding 70% could be undertaken without able assistance. The Council would like to extend its appreciation to the National Association of State Drug Abuse Program Coordinators, with a special thanks to its director, Rayburn Hesse, for assistance in designing the questionnaire and delivering the high rate of responses. We would also like to thank the staff of the International City Management Association, particularly Mary Ann Allard, for their work throughout the project. Finally, our sincerest appreciation must go to all the state drug abuse program coordinators who took the time necessary to complete a survey of this unusual length.

This report was prepared by Peter Goldberg, John Sessler and Nancy Schulte of The Drug Abuse Council staff, with the support help of Lilly Smith and Jean Johnson.

INTRODUCTION

Rational formulation of drug abuse policy at any level of government depends on a careful census of existing programs and expenditures as well as a thorough review of unmet problems and needs. During the last eighteen months, information of this type has been collected and published on drug abuse activities at the federal government level.¹

Now it is necessary to develop similar information on drug abuse activities at the state and local levels. As a first step in developing baseline information, The Drug Abuse Council, Inc. contracted with the International City Management Association in the Spring of 1972 to survey state and local governments' responses to the drug abuse problem. The purpose of the survey was not to generate precise financial and statistical data, which is, in many instances, unavailable. Rather, the purposes were.

- To elicit a general understanding of program needs.
- To uncover heretofore unrecognized or unsubstantiated areas of concern meriting further attention.

Two separate surveys were actually developed, one for states and one for the large cities and counties. The city and county survey was an abbreviated and modified form of the state survey. This survey was mailed to all cities with a population exceeding

50,000 and to all counties with a population exceeding 100,000 based on the 1970 census data. The city-county component of the survey is expected to be completed within the next two months and an analysis will be issued in a subsequent report.

METHODOLOGY

The state survey, which is reported here, was conducted in conjunction with the National Association of State Drug Abuse Program Coordinators. It includes all political jurisdictions defined as states in the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255). In the summer of 1972, the state questionnaire was mailed to the drug abuse program coordinators of all fifty states, the District of Columbia, Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Pacific Trust Territories.

The response to the state survey was excellent. Thirty-nine states, the District of Columbia, and Puerto Rico completed the questionnaire between July and September of 1972.² The response rate was especially heartening because the questionnaire was lengthy (over 100 questions) and complex, requiring the assistance of education and law enforcement officials as well as the main respondent, the state drug abuse program coordinator.³ In fact, considering the amount of time and effort required to complete the questionnaire, the inference can be made from the high response rate that there is a strong state interest in the problems of drug abuse.

Because of the length and complexity of the questionnaire, each state did not always complete each item. The results reported here are based on the

¹ *Federal Drug Abuse Programs: A Report Prepared by the Task Force on Federal Heroin Addiction Programs and Submitted to the Criminal Law Section of the American Bar Association and the Drug Abuse Council* (Washington, D.C.: Drug Abuse Council, 1972), pp. 1-531.

Peter B. Goldberg and James V. DeLong, "Federal Expenditures on Drug Abuse Control", in *Dealing With Drug Abuse: A Report to the Ford Foundation* (Washington, D.C.: Drug Abuse Council, 1972) pp. 300-328.

Federal Programs for the Control of Drug Abuse, in *Special Analysis Budget of the United States Government Fiscal Year 1974* (Washington, D.C.: U.S. Government Printing Office, 1973), pp. 284-294.

² One state returned its survey after September and could not be included in this analysis.

³ A complete copy of the state survey with the aggregate totals is included in appendix B.

total data available for each item and these totals will vary. The data discussed in the text and reported in the tables throughout the report will indicate the number (N=) of states responding.

The state questionnaire elicited responses to questions in the following areas: state administration and coordination; funding; data and epidemiology; treatment and rehabilitation; education and prevention; law enforcement; and technical assistance from the federal government.

In an effort to gain a more detailed understanding, the data was analyzed not only in the aggregate, but also, wherever appropriate, by state size (as defined by population) and by geographic region. Responses were received from all 10 of the large states, 24 of the 30 middle-size states, and seven of the 10 small states.⁴ (Appendices C and D contain a listing of all responding states broken down by size and region.)

The geographic breakdown used in this analysis was based on a standard quadrant system that included the northeast, north central, south and west regions.

Although the survey data was also broken down by HEW regions, the number of states responding in each of the ten regions was too small to permit any detailed analysis.

No discussion of methodology would be complete without pointing out some of the limitations of surveys in general, drug abuse surveys, and this survey in particular. At least six caveats are in order:

- The survey questions were designed to elicit responses from the greatest number of states possible regardless of the specificity of the data they were able to provide.
- The fact that some of the survey questions were quite general raises the possibility of different interpretations by different state coordinators. Thus, not all the statistics for a given question are necessarily uniform. But, again this does not undermine the purpose of the survey. Also, it should be noted that patently incorrect responses were eliminated from the analysis.
- The information requested by the survey was not necessarily the responsibility of the state drug abuse program coordinators. In fact, certain drug-related programs, notably education and law enforcement, were found to be primarily a local function and therefore reliable state-wide statistics were not available. However, even this information adds to the general understanding of the states' drug abuse re-

sponse, by learning what the states do not know, we find out something about states' priorities and responsibilities.

- Even when states were able to provide state-wide statistics, the numbers were of questionable accuracy. This is underscored by the fact that only seven states report testing drug-related data regularly for reliability and validity. This is but one indication of the primitive state of the art of statistics in the drug abuse field.
- The aggregate responses to many questions were frequently skewed by one or two large urban states with particularly large drug problems. However, because the confidentiality of the individual state returns has been guaranteed, it is impossible to point out how certain individual questions have been disproportionately influenced by the answer (or lack of one) from certain key states.
- The drug abuse field is a rapidly changing one. This is especially true for this particular survey since the states responded prior to the November, 1972 elections. Thus, in addition to the normal turnover of administrative and program personnel, the elected and appointed officials may have changed. This offers the possibility that program operations as well as budgetary allocations may have also changed.

Therefore, the survey results cannot in every instance be construed as an accurate picture of the current drug abuse activities within the states.

SUMMARY OF FINDINGS

The last section of the report lists specific findings from the data. There seem to be indications that problems may be developing in the states' effort to respond to drug abuse. These fall into three categories:

- Areas of concern which arise from either lack of information or a lack of communication between functional components of the state's program.
- Areas of concern recognized by the states themselves and cited in their responses to the technical assistance questions on the questionnaire.
- Areas of concern associated with the response of the state education system to the drug abuse problem.

These findings will be discussed in greater detail in the concluding section of the report.

The following analysis contains survey results for all states, with size and geographic breakdowns

⁴ Excluding American Samoa, Guam, the Virgin Islands and the Pacific Trust Territories.

whenever appropriate. The six topics to be covered are:

- Administration, coordination and funding
- Treatment and rehabilitation
- Private sector response
- Education and prevention
- Law enforcement
- Technical assistance.

Based on the data from this survey, it would be misleading to develop one general typology which could be considered representative of all states' drug abuse efforts. Indeed, no attempt was made to construct even a limited number of typologies predicated on either size or region which would accurately depict the overall response. Each state seemed to manifest enough distinct characteristics to caution against overly broad generalizations.

ADMINISTRATION, COORDINATION, AND FUNDING

Section 409 of the Drug Abuse Office and Treatment Act of 1972 makes funds available to the states, allocated on a formula basis, for preparing, implementing, and evaluating comprehensive state drug abuse plans. One precondition for receiving these formula grants is that each state must "designate or establish a single State agency as the sole agency for the preparation and administration of the plan, or for supervising the preparation and administration of the plan."⁵ As of the summer of 1972, 37 of the 41 states responding said that such an agency had been designated and established although some may have been operating under a temporary mandate when the questionnaire was completed. This section of the report will attempt to place the functions and responsibilities of these single State agencies in their proper perspective.

Fifteen of the states with established single State agencies reported as of the summer of 1972 that they had developed comprehensive master plans for drug abuse. Proportionally, more of the smaller states had developed these plans than either the middle sized or larger states. However, results from the technical assistance section of the survey indicate that the level of satisfaction with these already developed plans was not high: 8 of the 15 states with completed comprehensive master plans for drug abuse also asked for technical assistance in developing master plans.

Twenty-seven of the 37 states with single State agencies employed a chief executive officer whose drug abuse functions were a full-time responsibility. Not surprisingly, most of the smaller states did not have full time executive officers. The backgrounds of the chief executive officers have been primarily in the fields of health, medicine, and administration as opposed to law or law enforcement. Many of the

chief executive officers reported prior experience in the area of drug abuse ranging from field operations to program administration.

In administrative and structural terms, it was found that approximately one-half of the single State agencies operated as units within other state departments such as State Departments of Health. The remaining single State agencies were either independent departments, or offices within the Governor's office.

One of the most important functions of these newly established single State agencies will lie in their coordinating responsibilities. This applies to the programs of other state agencies as well as to those of local governments. Thus, each state drug abuse program coordinator was asked to define the structural relationships between the single State agency and the state's drug education programs, law enforcement programs, and drug treatment and rehabilitation programs. Table 1 shows the aggregated responses.

Table 1
Relationship Between the Single State Agency and State Drug Programs

Program	Single State Agency Has:			No State Level Narcotics Control Program
	Budgetary Amendment Authority	Some Policy & Management Control or Budgetary Review	Communications & Liaison	
Drug Education	6	8	21	1
Law Enforcement	5	4	24	3
Treatment & Rehabilitation	15	8	11	2

Two observations may be drawn from the Table:

- Many single State agencies exert only minimal control over the state's drug education and law enforcement programs.

⁵ Subsection (e) (1) of Section 409 of the Drug Abuse Office and Treatment Act of 1972.

- When the single State agency does exercise more authority, it is normally over the state's treatment and rehabilitation programs.

These findings most accurately describe the situation in the smaller and middle sized states. The larger states seem to invest slightly greater authority in their single States agencies.

One other facet of inter-agency relationships at the state level is somewhat surprising. In only 15 states⁶ out of 38 reporting did the single State agency participate as a member of the state's criminal justice planning agency. This body is responsible for the disbursement of the State's Law Enforcement Assistance Administration's block grant, and large amounts of LEAA money have been channeled into drug abuse prevention efforts.

A further requirement of the Drug Abuse Office and Treatment Act of 1972 states that each State plan shall:

provide for the designation of a State advisory council which shall include representatives of nongovernmental organizations or groups, and of public agencies concerned with the prevention and treatment of drug abuse and drug dependence, from different geographical areas of the State, and which shall consult with the State agency in carrying out the plan.⁷

Twenty-seven of 39 states reported that as of the summer of 1972 they had such advisory councils. In most of these 27 states, the council members were appointed by the governor. Seven of these states reported that their drug advisory councils were the same body that advised on alcoholism. The state drug abuse program coordinators were asked to describe the extent of the advisory council's responsibility by marking a 5 point scale from "strong" to "mostly ceremonial." Twenty-three responded to the question. Their answers averaged slightly in the direction of "strong responsibility." Similarly, when asked to characterize the working relationship between the advisory council and the single State agency in terms of program orientation and direction, most states indicated general satisfaction.

Because the creation of the single State agency is a prerequisite to receiving federal funds under the 1972 Act and also because this survey was conducted during the year of enactment, it was of interest to find out the degree to which the state-level purse string power of a newly-created agency affected local level policy making power

In Question 15, the state coordinators were asked

to check one of four descriptions of the relationship between the localities' policy-making autonomy (or lack of it) and their "heavy" or "not heavy" dependency on the single State agency for funding. While "heavy" is a somewhat subjective term, the analysis of data yielded by Question 15 suggests that the distinction between "heavy" and "not heavy" was not difficult for the coordinators to make.

The data was analyzed in the aggregate (Table 2); by geographic region (Table 3); and by state size (Table 4). The aggregate matrix (Table 2) shows over half of the states reported that local governments were heavily dependent on the state for financial aid but maintained program autonomy. The geographic and state size tables also suggest strong local program autonomy.

As governmental response to the problems of drug abuse continues to evolve and expand, the development of good state-local working relationships will be crucial. The results of this survey suggest that those states which generally perceive themselves as being heavy financers of local government drug abuse control efforts exert comparatively little policy control over the localities. Conversely, those states characterizing themselves as "not heavy" financial contributors to local efforts more often reported that they did actively exert policy control over the local programs. That those states which provide the least funds to localities would at the same time tend to exert greater policy control over them is seemingly a contradiction which may very well warrant more careful investigation.⁸

The states were also asked to provide data on total annual expenditures for drug abuse response. The purpose of these questions was not to generate hard financial data but rather to use the monetary figures as indices of the state's priorities within the area of drug abuse. However, the breakdowns on

⁸ The cities and counties have also been asked this question to compare their perception of the local-state relationship.

Table 2

Local Government Dependence on The Single State Agency (All States) (N = 35)

		Local Government's Financial Dependence on the State:	
		Heavy	Not Heavy
Local Government's Policy Relationship to the State:	Number of States With:		
	Dependent	2 (5.7%)	7 (20%)
	Autonomous	19 (54.3%)	7 (20%)

⁶ The total of 15 states was comprised of: 5 large—out of 9 responding, 7 middle—out of 22 responding, and 3 small—out of 7 responding.

⁷ Subsection (c)(3) of Section 409 of the Drug Abuse Office and Treatment Act of 1972.

these expenditures by functional area (e.g., law enforcement, treatment and rehabilitation, and education) were heavily reliant upon the information available to the state drug abuse program coordinator. Comparisons between responses to the various funding and expenditure questions in the survey strongly suggest that this information is not generally coordinated within one office. The area of law enforcement and education were the most problematic in that the discrepancies in the totals and breakdowns were the widest. This finding seems consistent

with the varying levels of coordinating responsibilities invested in the single State agencies. For this reason, no conclusions can be drawn about state priorities from the information reported.

However, thirty single State agencies reported that they are now responsible for submitting annual drug abuse budgets to their state legislatures. Thirty-four single State agencies reported that they had responsibility for reviewing proposals for Federal drug abuse funds. One could, therefore, expect that coordination will improve in the near future.

Table 3
Local Government Dependence on
The Single State Agency By Geographic Region

Northeast (N=7)		North Central (N=8)		South (N=11)		West (N=9)	
0	3 (43%)	0	2 (25%)	2(18.2%)	1(9.1%)	0	1(11.1%)
4 (57%)	0	3 (37.5)%	3 (37.5)%	6(54.5%)	2(18.2%)	6(66.6%)	2(22.2%)

Table 4
Local Government Dependence on
The Single State Agency By State Size

Large (N= 8)		Middle (N=21)		Small (N=6)	
0	3(37.5%)	1(4.8%)	3(14.3%)	1(16.6%)	1(16.6%)
4(50%)	1(12.5%)	13(61.9%)	4(19%)	2(33.3%)	2(33.3%)

IV

TREATMENT AND REHABILITATION

FUNDING

Of the many categories into which governmental response to drug abuse may be grouped, the states, as might be expected, were most active in the area of treatment and rehabilitation. Treatment and rehabilitation receive the largest share of the expenditures provided or controlled at the state level, and the states exert the greatest degree of control over treatment programs.

Of the funds that the states were able to identify as treatment or rehabilitation expenditures, approximately 85 per cent was spent in the large states and approximately 65% in the northeastern region.

State program coordinators were asked to estimate the total amount of money spent within the state during the previous year on treatment and rehabilitation. They were asked to make further estimations of the percentage of this total which came from various sources: local, state, federal, private, and other. Table 5 and the data analysis which follows should be viewed with the caveat that these are estimates. Survey research experience has demonstrated that questions demanding exact budget figures, which may be unavailable, often result in estimated or unanswered questions. By asking for estimates, 30 coordinators were able to answer the questions.

Overall, the source of 59 per cent of the treatment and rehabilitation expenditures estimated by the 30 responding states was the states themselves. Federal sources contributed 24 per cent and an additional 12 per cent came from localities within the state. However, it is important to note how the complexion of this breakdown changed when the responding states were examined by size and geographical region in Table 5.

Most of the money spent on treatment and rehabilitation was in the large states and in the north-east. As a result, the overall figures reflected these two groups of the states. In the middle and small sized states and in the south and western regions, the federal government was the largest source of money by a significant margin. Except for the small states, where local funds represented only 5 per cent of the total, local governments contributed about a constant 10 to 14 per cent of the money spent on treatment and rehabilitation.

In the future, when more exacting research is done on treatment and rehabilitation, these estimates can be used as a starting point for improved information. However, at the time the survey was conducted, the states' estimates of their own expenditures, as opposed to local, were probably more nearly accurate.

Table 5
Estimated Funding Sources For Treatment And Rehabilitation Programs
(N=30)

Source of Funds:	State Size			Geographical Regions				Overall
	Large	Medium	Small	NE	NC	S	W	
	8	16	6	5	8	11	6	30
Local	12%	14%	5%	13%	12%	10%	13%	12%
State	63%	33%	31%	72%	36%	38%	22%	59%
Federal	19%	46%	63%	15%	35%	46%	56%	24%
Private	5%	6%	1%	0	15%	6%	10%	5%
Other	1%	1%	0	0	2%	0	0	1%

TREATMENT PROCEDURES

Thirty-four states were able to identify approximately 110,000 heroin users in treatment; in 31 of these states the number reported included patients in both public and private programs; 3 states reported enrollment figures for only state operated programs. Over 4 out of every 5 (81 per cent) of these program participants are from 9 of the 10 large states, and less than 1 per cent resided in the 3 responding small states.

The states were using a variety of mechanisms to get addicts into treatment. The state coordinators were asked to estimate the percentage of total addicts in their states enrolled in treatment by the following procedures:

- Civil Commitment
- Criminal Commitment
- Pre-Trial Diversion
- Voluntary Commitment
- Other

Table 6 shows the distribution of addicts' motivation for treatment, and the number of states with addicts enrolled under the various procedures.

Twenty-three states reported having civil commitment procedures. Seven of these states, however, were not currently admitting addicts under this procedure. Responses from 12 of the 16 that were actively using civil commitment identified approximately 7,000 patients so enrolled.⁹ In no one state is this procedure used to admit more than 20 per cent of the patient population of that state; and, in

fact, this percentage is significantly lower than 20 per cent for most states. Since 9 of 17 states currently without a civil commitment procedure requested technical assistance in establishing one, this may indicate a future trend toward greater use of civil commitment.

Eighteen states reported that they have a total of just over 10,000 patients enrolled in treatment under criminal commitment procedures.

Eleven states reported a total of approximately 2,500 patients enrolled under pre-trial diversion programs.

Thirty-two states were also able to break down treatment modalities for 75,290, or approximately 70 per cent, of the identified heroin addict population in treatment. Two states, with a total addict-in-treatment population of approximately 35,000, were unable to supply the information.

Table 7 summarizes treatment modality enrollment in the aggregate, by geographic region, and by state size. It is striking, although hardly surprising, to note that almost twice as many patients were enrolled in chemotherapeutic (almost all methadone) programs as in drug-free programs. These figures are constant for all breakdowns.

Approximately 25 per cent of the states requested technical assistance in developing treatment and rehabilitation programs. Curiously, there was no significant variation in this percentage between states with or states without drug free programs, methadone programs, or waiting lists for entry into methadone programs.

METHADONE TREATMENT PROGRAMS

Thirty-three of the responding states identified 384 methadone dispensing centers. Seventy-three per cent of these centers are located in 9 of the

Table 6
Patients' Motivation For Treatment
(N = 110,000)

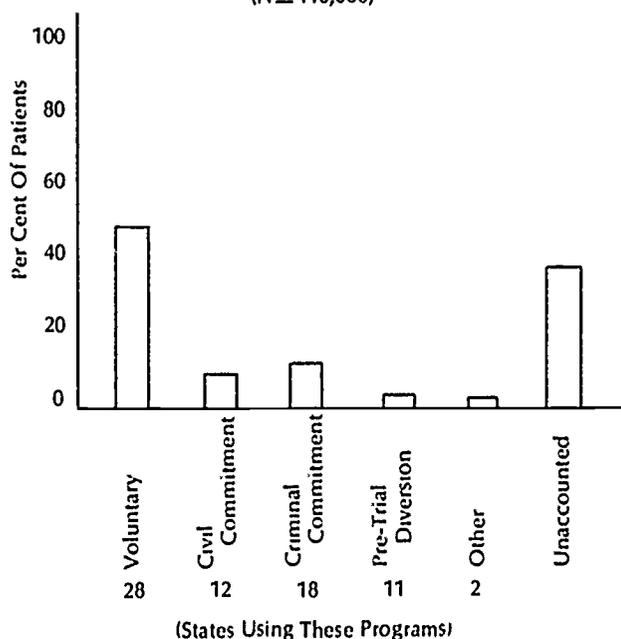


Table 7
Summary of Treatment Modality Enrollments

	Total Patients		Treatment Modality			Number of States Reporting
	Number	%	Chemical	Drug Free	Other	
All States	75,290	100	64%	33%	2%	32
State Size:						
Large	58,979	78%	65%	35%	<1%	7
Medium	15,824	21%	64%	26%	10%	22
Small	487	1%	57%	43%	—	3
Geographic Region:						
Northeast	46,194	61%	54%	45%	1%	7
North Central	10,021	13%	94%	6%	—	7
South	11,049	15%	63%	23%	14%	11
West	8,026	11%	87%	13%	—	7

⁹ Most of these patients are in one state.

10 largest states. Fifteen of the 33 responding states directly operated methadone maintenance programs. As of the summer of 1972, approximately 17,500 patients were enrolled in these state operated programs. The other methadone patients were in non-state operated treatment programs.

After the questionnaire was completed by the respondents, the federal government formulated new guidelines for admission to methadone programs. These guidelines may have had the effect of rendering some of this survey's methadone data to the historic interest category. However, the states' practice prior to federal intervention may be of interest for comparison. As of the summer of 1972, the 15 states directly operating such programs had established multiple criteria for admission. Ten of the 15 states required at least:

- A minimum age (also a Federal requirement)
- A specified number of years of addiction
- Failure in abstinence

Fifteen states reported some kind of waiting list for methadone programs within their states. In 11 of these states, the total numbered about 8,700. Table 8 describes the situation of the 8 states for which more detailed information is available.

Eleven of the 15 states operating their own programs were able to provide the age distribution of their patient population. Two of the 11 states had a total of just over 400 patients under 18 years old enrolled in state operated methadone maintenance programs. Seven of the 11 reporting states had about 1300 clients over 40 enrolled in these programs. Nine states reported no one under 18 enrolled in state operated methadone maintenance programs.

In no state did the percentage of males in the patient population drop below 75 per cent and it ranged up to 100 per cent.

Ten states provided an ethnic breakdown of their patient population in state operated methadone maintenance programs. In those 10 states nearly three-fourths of the patient population was non-white.

Ten of the 15 states that operated methadone maintenance programs reported a total of 15,600 patients, one-half of whom were employed.

The rules governing methadone take-home privileges varied considerably. Some states only required methadone patients to be enrolled for four weeks before take home privileges were given; others insisted on 52 weeks of participation; and one state prohibited all take-home privileges.

Very few states provided information on the provision of supporting social services in state operated maintenance programs. Those 8 states that did report indicated they provided a wide range of services including vocational training and counseling, family counseling, education programs, individual therapy, and group therapy. The survey did not question the participation in these services or their quality, thus the level of these services is not known. However, a rough indication of the level of services available could be inferred by the ratio of patients to staff in the state programs.

Of the 15 states which reported operating their own methadone program, 8 provided information on staffing levels.¹⁰ This information indicated an average ratio of 9 patients to each staff person and 15 patients to each professional staff person. However, in the 4 states with the largest program enrollments (over 1,000), the ratio of patients to professional staff ranged from 11:1 to 24:1.

Ten of the 15 state-operated methadone programs

¹⁰ Part-time staff was treated as one-half full-time.

Table 8
Characteristics Of Waiting Lists For Methadone Programs
(N=8)

State Size	Total Patients in Treatment	% In Methadone Treatment	# Of Persons On Waiting List (For Methadone)	Average Wait (Weeks)	Ratio of Persons Waiting To Persons In Methadone Treatment
Large	10,000	NR *	150	2	—
	3,250	23	150	NR *	.2
	5,200	44	1075	5	.47
	3,904	73	1346	NR *	.47
Middle	230	85	130	10	.67
	500	98	300	6	.61
	4,000	50	80	3-4	.04
	380	97	400	8-12	1.08

* NR=Not Reported

had attempted some type of program evaluation. Such evaluations were conducted by all 9 states with program enrollments exceeding 1,000. In the 5 states without program evaluation, each had fewer than 400 participants in their programs.

Twenty-one of the 41 states asked for assistance in

evaluating treatment and rehabilitation programs. Of the 10 states evaluating state operated methadone programs, 4 felt need of additional assistance. Four of the 5 states that had not attempted any evaluation wanted to receive technical assistance in that area.

PRIVATE SECTOR RESPONSE

Most approaches to drug abuse emphasize the actions of government. The private sector, however, must also be considered as an important component of society's response to the problem. Many types of private organizations have been active in education and treatment, for example. In many localities, such organizations were the sole resource available prior to the recent increases nationally in expenditures and public concern. However, in the survey, only the states' involvement with private business and industry was examined.

At least two important interrelationships existed between the problems associated with drug abuse and the operations of business. One concerned the problems of dysfunctional drug abusers in the labor force. The other concerned the employment of former heroin addicts.

Fourteen of 38 states attempted to define the problem of drug abuse among the labor force. Five of these states asked for help in establishing programs to assist business.

Of the 24 states that had not attempted to define the problem, half requested assistance to survey drug abuse among the labor force, and two-thirds requested help in establishing programs to assist business and industry. This interest in programs to assist business was greatest in the large states with 8 of the 10 requesting assistance.

Only 12 out of 38 states report they are actively engaged in special programs to hire rehabilitated

drug abusers. Thirty-five state drug abuse program coordinators were able to characterize the prevailing attitude among employers towards hiring former heroin addicts. Sixty per cent categorized the attitude as "resistant." The prevailing attitude among private employers in states with active hiring programs did not differ from states without them. The state coordinators' responses are presented in Table 9.

Analysis of data by region and state size showed no discernible differences. Private employers were overwhelmingly resistant to hiring former drug abusers.

Sixteen states asked for technical assistance in developing vocational rehabilitation and manpower programs. Most of these states had characterized the attitudes of employers as "resistant."

Table 9
State Coordinators Estimation of Private Employers' Attitudes
Towards Hiring Former Drug Abusers
(N = 35)

Response	Number of States	Per Cent of Respondents
Enthusiastic	0	0
Cooperative	3	9
Show little concern	8	23
Resistant	21	60
Absolutely opposed	3	9

EDUCATION AND PREVENTION

Primary and secondary school education is usually the responsibility of local government, drug abuse education in the public schools is no exception. Even though 37 of 41 states have one person within the State Department of Education with overall responsibility for administering drug education programs, only 18 State Departments of Education issue a uniform drug education policy for the public school systems and fewer than half of these states evaluate the results of such policies.

Similarly, survey results showed that decisions on the actual presentation of drug information were left to the discretion of local school systems in 32 of 39 states. Furthermore, this drug information was usually presented through a variety of different techniques. In three-quarters of the states, 4 or more different techniques were used in the public schools. The most frequently mentioned techniques included audiovisuals, group discussions, and lectures by experts. Not surprisingly, the methods cited less frequently, such as field trips and student initiated research were more time-consuming and more demanding than the others. One interesting development was that 5 states specifically added "values clarification" to the list of drug education approaches. Values clarification is seen by educators as an important component of "affective education" which approaches treating more than factual material by focusing on the needs, perceptions, and emotions of students.

The course materials for drug education in the public schools come from a variety of sources, both public and private. Among the most frequently mentioned sources of these materials are the State Departments of Education, commercial organizations, and materials developed by the teachers themselves. Only one-third of the 33 states reporting said basic course materials were modified for minority students. Such modifications were made in 6 of the 9 large states. Active student participation in the formulation of drug-related policies and educa-

tion programming was more common, occurring in 22 of 33 states. Such participation was most common in the large and small states.

Within the individual school systems themselves, the responsibility for programming and administering drug education courses was shared by the classroom teacher, the physical education or health teacher, guidance counselor, and biology teacher. In fact, 23 of the 36 states responding said that drug education programming was left to the individual teacher so that drug information could be integrated with the rest of the curriculum.

The teachers responsible for drug education courses did, however, usually receive some form of training. In half the responding states such training was supported, in part, by the State Department of Education. The length of the training periods varied considerably, from as little as eight hours to as much as twelve weeks. Refresher courses were required in only five states. Drug education and training courses are available to other interested adult groups in nearly all the states.

No state required that guidance counselors be trained and available to students for individual consultations about drugs, though 17 states did recommend such a procedure. However, the fact that only 10 out of 26 states, or 38 per cent, allowed guidance counselors to extend the privilege of confidentiality to students with drug-related problems would seem to undermine the potential effectiveness of individual counseling in the public school systems.

Even though drug education is primarily a local responsibility, state officials were asked to characterize, in general terms, the usual action of a high school taken against students found possessing or selling marijuana or heroin. The concern was not with the specific types of responses taken by high school authorities, but whether or not these actions varied among four different crimes—possession of marijuana, sale of marijuana, possession of heroin,

and sale of heroin. The survey indicated that, according to the state officials' impression.

- In 6 states, the high schools did not distinguish between possession of marijuana and sale of heroin;
- In 9 states they usually did not distinguish between possession of marijuana and possession of heroin;
- In 17 states, high school authorities did not distinguish between the sale of marijuana and heroin;
- In 10 states, high schools did not distinguish between possession and sale of marijuana;
- In 16 states, no distinction was made between possession and sale of heroin.

The first three findings are especially disturbing in view of what is known about the differences between the two drugs.

Because drug education is primarily the responsibility of local governments, reliable financial data was not available on a state-wide basis. It should be noted, however, that nearly all of the states reported receiving federal money from the Office of Education and many received federal money from the Law Enforcement Assistance Administration for their drug education efforts.

The states' request for technical assistance in the area of education and prevention indicated a greater interest in receiving help to evaluate existing programs than in developing either new programs or new course materials.

VII LAW ENFORCEMENT

The law enforcement section of the survey had the lowest response rate of any of the sections. Some possible explanations for this include:

- The statistics associated with drug abuse law enforcement within a state were not recorded on a state wide basis.
- There was a reluctance on the part of law enforcement agencies to share this information.
- The information requested was not readily available.
- There was a lack of coordination with the state's criminal justice planning agency.

The low response rate was especially disappointing given the importance and controversial nature of the role of law enforcement in a comprehensive approach to drug abuse problems. Consequently, even though the information was incomplete, it is

Table 10
Year Narcotics Units Established By State Size
(N = 28)

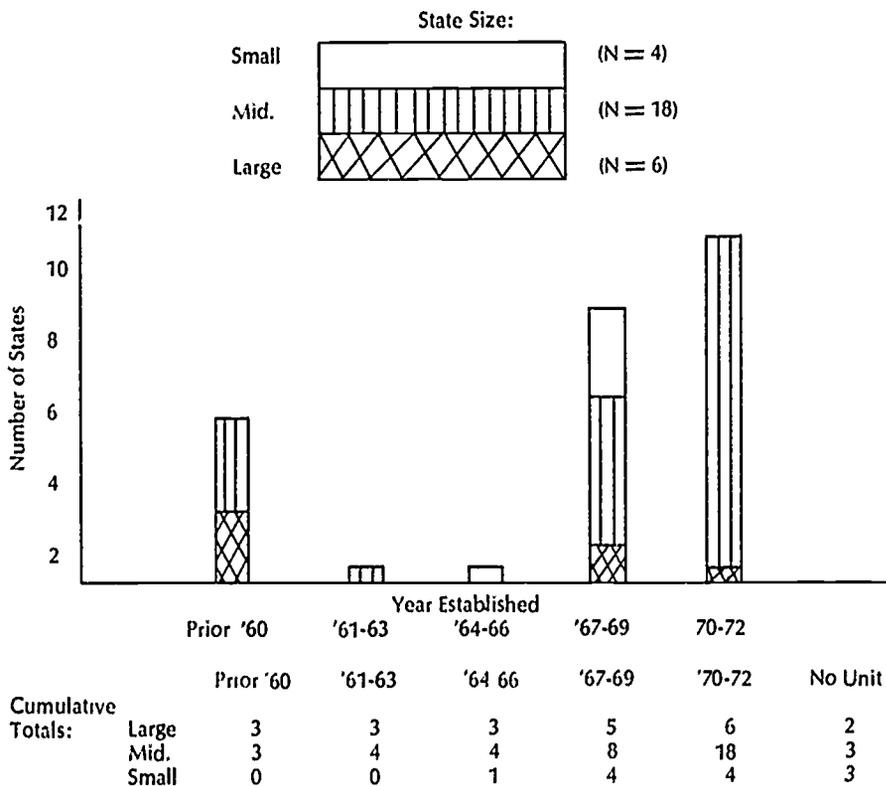
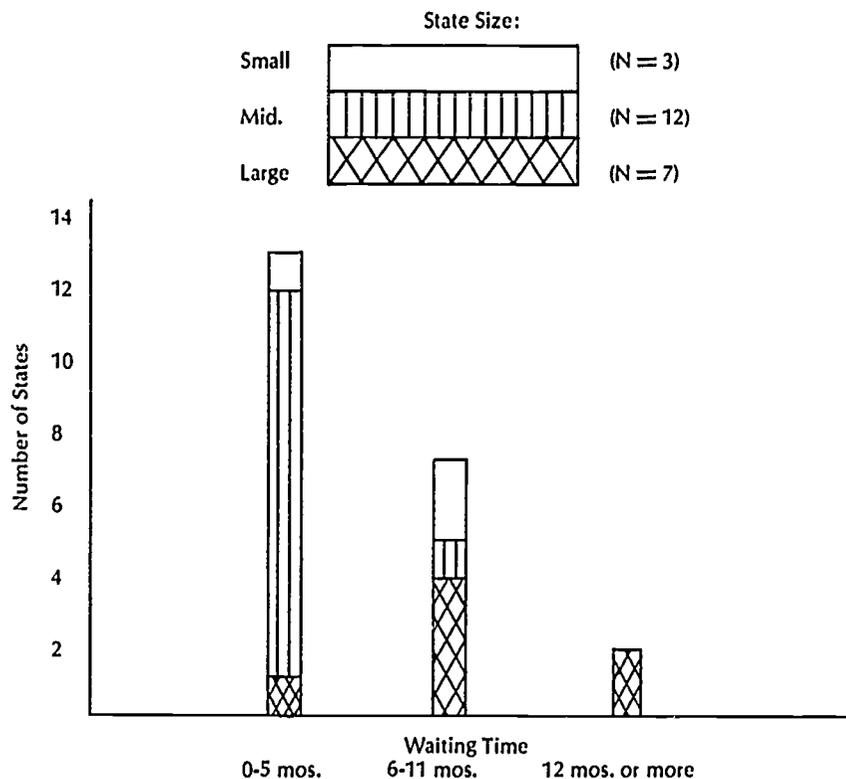


Table 11
Time Between Arrest and Trial By State Size
(N = 22)



offered as an impetus for public discussion and future analysis.

Thirty-two out of 40 reporting states maintained special narcotics units. Table 10 shows the distribution of the establishment of 28 of these special narcotics units over time, differentiated by state size. Cumulative totals of established, functioning narcotics units are given below the table. (No answers were received from 4 states)

Twenty states were able to provide figures on arrests for the possession and sale of marijuana and heroin over a twelve month period.¹¹ While the survey attempted to distinguish between the offenses of possession and sale, many of the states responding combined the two categories. Moreover, as previously indicated, statistics compiled by the state

police did not necessarily include local arrests. In the 20 states reporting, there were a total of over 8,000 heroin arrests and over 20,000 marijuana arrests. The more important statistics would be on the outcomes of these arrests (e.g. pretrial diversions, convictions, average sentences) but so few states provided this information that any analysis would be meaningless.

We asked the states to estimate the average length of time between arrest and trial in heroin possession and sales cases. Table 11 shows the distribution of these waiting times differentiated by state size. All but one of the largest states reporting had waiting periods of 6 or more months. Two small and only one middle sized state reported similarly long intervals.

Sixteen states reported using a plea bargaining mechanism in heroin associated cases. No discernible pattern emerged between reported waiting times and the extent to which plea bargaining was used.

¹¹ This twelve month period was not the same for all states. All except one state reported for a twelve month period sometime between the summers of 1970 and 1972.

VIII

TECHNICAL ASSISTANCE

Section 229 of the Drug Abuse Office and Treatment Act of 1972 addresses the problems and technical assistance needs of state and local agencies. In performing its functions, the Special Action Office for Drug Abuse Prevention may provide technical assistance "to analyze and identify State and local drug abuse problems and assist in the development of plans and programs to meet the problems so identified."¹²

In order to help clarify some of these technical assistance needs, the states were presented a list of 26 possible areas in which assistance could be requested. The respondents were not asked to rank order their needs. There was no restriction placed upon the number of areas of technical assistance which could be requested. No "other" category was included. The aggregated tabulations for the 26 areas of possible technical assistance are presented below in order of decreasing frequency of response. Thirty-six states listed some areas of need. Five did not list any.

Total States Requesting Technical Assistance (N = 36)		<i>Number of States Requesting</i>
<i>Type of Technical Assistance</i>	<i>Number of States Requesting</i>	
Developing the state master plan.	27	19
Surveying the incidence and prevalence of drug abuse.	24	19
Establishing programs to assist business and industry.	23	17
Developing and operating a uniform data system.	22	16
Evaluating school and community education and prevention programs.	21	16
Evaluating treatment and rehabilitation programs.	21	16
		16
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		10
		10
		10
		9
		5

¹² Subsection (b) (1) of Section 229 of Drug Abuse Office and Treatment Act of 1972.

Half of all the states requested assistance in 9 or more possible areas, and one-quarter of the 41 states asked for assistance in more than 13 areas.

Five states did not list any areas at all. In terms of total numbers of responses, the smaller states asked for as many types of technical assistance as the larger states although the areas requested were not necessarily the same. This same pattern was also evident when the returns were analyzed by region.

The areas of technical assistance most frequently requested emphasized, for the most part, the management function of planning and evaluation rather than direct program operations. The one exception was in establishing programs to assist business and industry. As might be expected, 4 of the 6 areas of technical assistance most frequently requested are also necessary preconditions for receiving state formula grants under section 409 of the Drug Abuse Office and Treatment Act of 1972. However, because technical assistance was not requested for all such areas required under this federal law, the returns may be indicative of increasing state interest in accumulating and evaluating existing and available information prior to developing further program operations.

The following tables list the areas of technical assistance most frequently cited by the states when separated by size.

**Largest States (N = 8)
(Total: 10)**

Type of Technical Assistance	Number of States Requesting
Establishing programs to assist business and industry.	8
Developing the state master plan.	7
Developing and operating programs within the criminal justice system.	6
Developing and operating a training program.	6
Surveying the incidence and prevalence of drug abuse.	6
Evaluating school and community education and prevention programs.	6

**Middle Sized States (N = 22)
(Total: 24)**

Type of Technical Assistance	Number of States Requesting
Developing the state master plan.	16
Surveying the incidence and prevalence of drug abuse.	15
Developing and operating a uniform data system.	14
Establishing programs to assist business and industry.	13
Evaluating treatment and rehabilitation programs.	13
Evaluating school and community education and prevention programs.	12

**Small States (N = 6)
(Total: 10)**

Type of Technical Assistance	Number of States Requesting
Developing the state master plan.	4
Developing and establishing a licensing system.	4
Developing and operating a training program.	4
Surveying drug abuse among the labor force.	4
Developing proposals for community assistance.	4

Noticeable differences were discernible in the areas of technical assistance requested between the small states, on the one hand, and the middle and larger states, on the other. With the exception of developing a state master plan, the smaller states expressed more interest in receiving assistance in specific program areas. Establishing programs to assist business and industry, however, was an exception. This was noted much more frequently in the larger states than the smaller states, although many small states did express an interest in receiving assistance in surveying drug abuse among the labor force.

The one area of technical assistance showing the widest disparity among the states according to size was in developing and operating programs within the criminal justice system. This was a frequent area of concern cited by the larger states, only infrequently mentioned by the middle sized states and not mentioned at all in the smallest states.

The most frequent responses to the technical assistance question were also broken down by region.

**Northeast (N = 6)
(Total: 7)**

Type of Technical Assistance	Number of States Requesting
Establishing programs to assist business and industry.	5
Developing and operating a training program.	4
Developing vocational rehabilitation and manpower programs.	4
Surveying the incidence and prevalence of drug abuse.	4

**Northcentral (N = 8)
(Total: 9)**

Type of Technical Assistance	Number of States Requesting
Developing the state master plan.	7
Surveying the incidence and prevalence of drug abuse.	7
Evaluating treatment and rehabilitation programs.	7
Establishing programs to assist business and industry.	6
Developing and operating a uniform data system.	6

South (N = 13)
(Total: 14)

Type of Technical Assistance	Number of States Requesting
Developing the state master plan.	11
Developing education and prevention programs.	9
Establishing programs to assist business and industry.	9
Developing and establishing a licensing system.	8
Surveying the incidence and prevalence of drug abuse.	8
Evaluating school and community education and prevention programs.	8
Developing proposals for community assistance.	8

West (N = 9)
(Total: 11)

Type of Technical Assistance	Number of States Requesting
Developing and operating a uniform data system.	7
Developing the state master plan.	6
Developing a program for local physicians.	5

Type of Technical Assistance	Number of States Requesting
Surveying the incidence and prevalence of drug abuse.	5
Evaluating school and community education and prevention programs.	5
Evaluating treatment and rehabilitation programs.	5

Regionally, fewer significant variables were discernible. In part, this may be attributed to the small size of the total numbers. One anomalous regional difference concerned the frequency of requests for assistance in developing programs for local physicians in the west and north central states and the absence of this concern in the northeastern and southern states.

Thirty states indicated a willingness to pay for technical assistance with the federal planning funds to be made available under Section 409 of the Drug Abuse Office and Treatment Act of 1972. Only 8 states, however, reported that there were supplemental funds available that could also be used to pay for technical assistance requirements: none of these 8 states was small.

IX CONCLUSIONS

The two purposes for this survey were stated at the beginning of this report. One was to elicit a general understanding of program needs; the other was to uncover heretofore unrecognized or unsubstantiated areas of concern meriting further attention. These areas fall into three general categories.

First, there were areas of concern which arose from either a lack of information or a lack of communication between functional components of the state's drug abuse program. The survey showed:

- A general lack of knowledge about allocation of state expenditures on drug abuse;
- A growing financial dependency by local governments on the single State agency. The creation of the single State agency is a prerequisite to receiving funds under section 409 of the Drug Abuse Office and Treatment Act of 1972. In most states, however, local governments maintained policy-making autonomy despite fiscal dependency.
- A lack, at the state level, of tested and reliable data on many components of the drug abuse problem within the state.
- An almost universal lack of statewide statistics on law enforcement activities in spite of the large number of states reporting the existence of special narcotics units within the state police force.
- A problem of communication and coordination between the single State agency and the state's criminal justice planning agency.
- Problems with the completed comprehensive state plans as well as those in all stages of development.

Second, there were areas of concern recognized by the states themselves and cited in their responses

to the technical assistance questions. The areas of need most frequently noted by the states were:

- Help with establishing the state master plan.
- Help in surveying the incidence and prevalence of drug abuse.
- Help in establishing programs to assist business and industry with programs to employ former addicts.
- Help in developing and operating a uniform data system.

Third, there were areas of concern associated with educational systems' response to the drug abuse problem. These were:

- The lack of distinction made by high schools in many states between heroin and marijuana when action is taken against a student for possessing or selling drugs. In addition, many states reported no distinction was made between the offenses of possession and sale of these drugs.
- The lack of drug abuse-related training for high school guidance counselors.
- The inability of high school guidance counselors to extend the privilege of confidentiality to those students voluntarily seeking help.

The second area of concern, the various technical assistance needs, were identified by the states themselves. The first and third areas of concern, however, became evident only as a result of this survey. It is anticipated that the results of this study, coupled with an analysis of the forthcoming Survey of City-County Drug Abuse Activities 1972, will yield a more detailed map of problems from which more effective public policy approaches will emerge.

**APPENDIX A:
FORWARDING LETTER**

****DRUG ABUSE COUNCIL
**NATIONAL ASSOCIATION OF STATE DRUG ABUSE PROGRAM COORDINATORS
INTERNATIONAL CITY MANAGEMENT ASSOCIATION

Dear State Drug Abuse Program Coordinator:

The International City Management Association, The National Association of State Drug Abuse Program Coordinators and the Drug Abuse Council are co-sponsoring a comprehensive national survey of all state actions in the area of drug abuse.

Our organizations have combined efforts in order to facilitate your response. The length and difficulty of the questionnaire could be a burden; it can however also present a significant opportunity. To date there has been little orderly and systematic gathering of data on drug abuse response at the state or local level. The responses to this survey could form the foundation of greater understanding of state activities, priorities, philosophies and potentialities in the field of drug abuse.

A full set of returns will aid NASDAPC design its technical assistance programs. Further, the results will help the Drug Abuse Council suggest ways in which future federal resources might be brought to bear more effectively on the problem. Also, the results of the questionnaire will be used to complement a similar survey being conducted at the city and county level. Finally, and of equal importance, an analysis of the results will be made available to all respondents in order to assist them in their work.

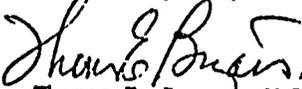
We hope your cooperation will insure complete and comprehensive returns. This survey is one more important step in the process of developing effective, coordinated approaches to the multi-faceted problems of drug abuse. Your valuable contribution makes this effort possible, and it is sincerely appreciated.

Please return the questionnaire as soon as possible in the enclosed postage-paid envelope.

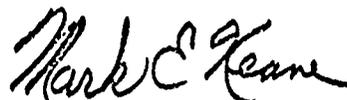
If you have any questions or comments, please do not hesitate to contact either Peter Goldberg of the Drug Abuse Council (1828 L Street, N.W., Washington, D.C. 20036, Ph. 202-785-5200) or Mary Ann Allard of The International City Management Association (1140 Connecticut Avenue, N.W., Washington, D.C. 20036, Ph. 202-293-2200).

Thank you for your assistance.

Sincerely yours,


Thomas E. Bryant, M.D.
President,
Drug Abuse Council


Rayburn F. Hesse
Chairman,
National Asso. of State
Drug Abuse Program
Coordinators


Mark E. Keane
Executive Director,
International City Man-
agement Association

**APPENDIX B:
QUESTIONNAIRE**

Aggregate Responses Noted Where Available

Municipal Year Book Urban Data Service

1140 Connecticut Avenue Northwest Washington DC 20036

International City Management Association



STATE COMPREHENSIVE DRUG ABUSE PROGRAMS--1972

DEFINITION: The term "drug abuse prevention function" means any program or activity relating to drug abuse education, training, treatment, rehabilitation, or

research, and includes any such function even when performed by an organization whose primary mission is in the field of drug traffic prevention functions, or is unrelated to drugs.*

A. STATE ADMINISTRATION AND COORDINATION

1. Does your state have a single state agency with overall responsibilities for drug abuse prevention functions?YES (37) NO (4)

If "YES," please give the title of the agency, name of the chief executive officer, and the address.

Agency Title or Name: _____
 Executive Officer: _____
 Officer's Title: _____
 Mailing Address: _____
 _____ ZIP _____

If the single state agency has an administrative officer in addition to the chief executive officer, please give his name: _____

2. Is the chief executive officer's drug abuse function a full-time responsibility?YES (27) NO (10)

3. Is the chief executive officer's primary background in: (Check one)

10 1. Health and medicine
2 2. Law enforcement
9 3. Administration and management
7 4. Other (specify): Health and Administration

* Defined as such in sec. 103 of PL 92-255.

4. Has the chief executive officer had any prior experience in dealing with drug abuse?YES (28) NO ()

If "YES," please describe this prior experience. _____

5. Is the single state agency referred to in Question 1: (Check one)

- 9 1. An independent department or agency?
- 17 2. A unit within a department?
- 9 3. An office within the Governor's office?
- 0 4. A multi-agency council?
- 2 5. Other (explain): _____

6. Please define to the best extent possible, the structural relationship between the single state agency and the various drug programs.

Drug programs	Structural relationships:					Does not exist in state
	Communica- tion and liaison	Policy control	Management control	Budgetary review	Budgetary amendment authority	
a. State's drug educa- tion program	_____	_____	_____	_____	_____	_____
b. State's narcotics control program	_____	_____	_____	_____	_____	_____
c. State sponsored drug treatment program ..	_____	_____	_____	_____	_____	_____

7. Does your single state agency have an advisory council (as defined in PL 92-255, sec. 409 (e) (3) which states that "each state plan shall provide for the designation of a State advisory council which shall include representatives of nongovernmental organizations or groups, and of public agencies concerned with the prevention and treatment of drug abuse and drug dependence, from different geographical areas of the State, and which shall consult with the State agency in carrying out the plan;") ?YES (27) NO (12)

8. Is this advisory council the same council that advises on alcoholism?YES (7) NO ()

9. Please describe the functions of your advisory council in terms of responsibility. (Circle one only)

Strong 1 / 2 / Avg. 2.4 / 3 / 4 / 5 Cereonial

10. Please describe the working relationship of the advisory council to the single state agency in terms of program orientation direction. (Circle one only)

Good 1 / 2 / 3 / 4 / 5 Not good
 / Avg. 2.2

11. What method is used to appoint the members of the advisory council? (Check one)

- 1 1. Election
- ~~22~~ 2. Appointment by the Governor
- 2 3. Appointment by State Legislature
- 2 4. Other (specify): _____

12. What is the length of term of the members of the advisory council? _____ years

13. Do the terms of the advisory council members overlap?YES (21) NO (5)

14. Does your state have local advisory councils?YES (15) NO (18)

15. Which of the following statements would best define the relationship of the single state agency and the various local governments? (Check one)

- 2 1. Local government programs are heavily dependent upon state financial aid, and the single state agency actively asserts policy control over local government programs.
- 19 2. Local government programs are heavily dependent upon state financial aid, but local governments operate their drug program relatively autonomously.
- 7 3. Local government programs are not heavily dependent upon state financial aid, but the state retains and actively asserts policy control over local government programs.
- 7 4. Local government programs are not heavily dependent upon state financial aid and they operate autonomously.

16. Does your state have a comprehensive master plan for drug abuse? ...YES (15) NO (24)

17. Has an agency been designated to develop such a plan under Public Law 92-255?YES (33) NO (6)

If "YES," name that agency: _____

18. Does the chief executive officer or single state agency make an annual report on the state of the drug abuse problem and the state's efforts to control it?YES (24) NO (11)

(PLEASE SEND A COPY OF THE REPORT IF IT IS AVAILABLE.)

B. FUNDING

19. What is the latest annual budget of the single state agency? \$ _____

Please give the dates of the fiscal year for this budget..... / to /
(Show month/year to month/year)

20. How large is the professional staff of the single state agency to the nearest one-half man year?

21. How much total money is estimated to be spent annually by your state for drug abuse response? \$ _____

22. What percentage of these funds are expended for the following functions?

- a. Law enforcement %
 - b. Treatment and rehabilitation %
 - c. Education, prevention, and training %
 - d. Research %
 - e. Planning and coordination %
 - f. Other (specify): _____ ... %
- TOTAL 100%

23. In what year were funds first allocated in the state budget specifically for drug abuse response? 19 _____

24. Does the single state agency have the responsibility for reviewing proposals for federal drug abuse funds? YES (34) NO (4)
 If "NO," whose responsibility is this? _____

25. Is the single state agency responsible for submitting an annual drug abuse budget to the state legislature? YES (30) NO (7)
 (PLEASE SEND A COPY IF AVAILABLE.)

C. DATA AND EPIDEMIOLOGY

26. Which agencies in the state provide data on drug abuse and drug abusers?

<u>Agency Name</u>	<u>Kind of Data</u>	<u>Source of Data</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If additional space is required to answer this question, attach extra sheets.)

27. Is this data tested regularly for reliability and validity? YES (7) NO (32)

28. Has any state agency or private agency conducted a statewide survey of drug abuse since 1971? YES (6) NO (32)

29. Based upon available data, please estimate the number of:
 a. Casual users (anyone who has experimented at least once)
 b. Regular users (anyone estimated to be using at least 6 times a month) _____

What is the source of this data? _____

30. Has the state attempted to define the problem of drug abuse among employees of business and industry within the state? YES (14) NO (24)



31. How would you characterize the generally prevailing attitude among employers towards hiring former drug abusers? (Check one)

- 0 1. Enthusiastic
- 3 2. Cooperative
- 8 3. Have shown little concern
- 21 4. Resistant
- 3 5. Absolutely opposed to hiring rehabilitated drug abusers

32. Is the state actively engaged in special programs to hire rehabilitated drug abusers?YES (12) NO (26)

D. TREATMENT AND REHABILITATION

33. How much total money is estimated to have been spent within the state on treatment and rehabilitation within the past year? \$ _____ (22-27)

34. Approximately what percentage of treatment and rehabilitation programs are funded by the following sources?

a. Local jurisdictions	_____ %
b. State	_____ %
c. Federal	_____ %
d. Private sources	_____ %
e. Other (specify): _____	_____ %
TOTAL	100%

35. Does your state provide funds for community assistance programs?YES (29) NO (11)

36. Does your state have a civil commitment procedure?YES (23) NO (17)

If "YES,"

a. Which agency is responsible for administering the civil commitment procedure? _____

b. Does this agency also operate the civil commitment treatment program?YES (19) NO (4)

c. Does the civil commitment treatment program provide for involuntary treatment?YES (18) NO (5)

d. Are these programs evaluated?YES (14) NO (9)

If "YES," by whom? _____

37. In addition to the community funded programs, does the state also operate abstinence or drug free programs?YES (17) NO (23)

If "YES," are these programs evaluated?YES (14) NO ()

If "YES," by whom? _____

38. Does the state require uniform reporting from all treatment and rehabilitation agencies?YES (12) NO (27)



39. How many heroin users are currently enrolled in drug treatment and rehabilitation programs within the state?

Does this number refer to enrollees in: (Check one)

- 1. State operated programs only?
2. All programs, public or private, operating within the state?

40. Approximately what percentage of the users are enrolled for the following reasons? (Please indicate primary reason only)

- a. Voluntary
b. Civil commitment
c. Criminal commitment
d. Pre-trial diversion
e. Other (specify):
TOTAL 100%

41. How many of the users are currently enrolled in the following treatment modalities?

- a. Therapeutic communities
b. Methadone maintenance
c. Methadone detoxification
d. Narcotic antagonist
e. In-patient abstinence
f. Out-patient abstinence
g. Other (specify):

42. Who licenses methadone maintenance programs in your state?

43. How many different methadone dispensing centers are there in the state? ...

44. Please define the process one must go through in order to obtain state approval to dispense methadone.

45. Does your state directly operate a methadone maintenance program? ...YES (15) NO (25)

46. Please indicate the number of patients currently enrolled in state operated methadone maintenance programs?

47. Please indicate the approximate distribution by percentage of the ages of this patient population.
a. Below 18
b. 18-21
c. 22-30
d. 31-40
e. Over 40
TOTAL 100%

48. What is the percentage of males in the patient population?



49. Please indicate the approximate distribution by percentage of the races of the patient population.

- a. White %
 - b. Puerto Rican %
 - c. American Indian %
 - d. Black %
 - e. Mexican American %
 - f. Other (specify): _____ ... %
- TOTAL 100%

50. What are the admission requirements to methadone maintenance programs? (Check all applicable)

- a. Minimum age
- b. Years of addiction
- c. Proof of addiction
- d. Place of residence
- e. Failures in abstinence
- f. Other (specify): _____

51. Do you currently have a waiting list for the methadone maintenance program?YES (15) NO (9)

If "YES,"

- a. How many names are on the list? _____
- b. What is the present average length of time spent on the waiting list before admission to the program is secured? (State in weeks) _____
- c. What percentage of users drop off the list before admission to the program is secured? %

52. How long must a patient be enrolled in a methadone maintenance program before he is allowed to take home more than a daily supply of methadone? _____ weeks

53. How many methadone patients in state operated programs are currently receiving the following ancillary services?

- a. Vocational training and counseling _____
- b. Family counseling _____
- c. Education programs _____
- d. Individual therapy _____
- e. Group therapy _____
- f. Other (specify): _____ ... _____

54. How many of the methadone patients in the state operated programs are presently employed? _____

55. How many people are employed to administer the state operated methadone program?

- a. Full-time paid professionals _____
- b. Part-time paid professionals _____
- c. Full-time paid non-professionals _____
- d. Part-time paid non-professionals _____
- e. Volunteers _____



56. Has any attempt been made to measure the effectiveness of the methadone program?YES (10) NO (5)

If "YES," please describe the method used to evaluate the effectiveness and the results: _____

E. EDUCATION AND TRAINING

57. Does the State Department of Education issue a uniform drug education policy for the public school system?YES (18) NO (21)

If "YES," are the results of such programs evaluated?YES (7) NO ()

If "YES," by whom? _____

58. Does one person within the State Department of Education have overall responsibility for administering the drug education program?YES (37) NO (4)

If "YES," what is the title and address of the administrator of this program?

Name: _____
 Title: _____
 Address: _____

 _____ ZIP _____

59. What is the annual state budget for drug abuse education? \$ _____

Which of the following federal agencies are supplying funds for these purposes?

Agency	Amount
a. Office of Education	\$ _____
b. National Institute of Mental Health	\$ _____
c. National Clearinghouse for Drug Abuse Information	\$ _____
d. Law Enforcement Assistance Administration	\$ _____
e. Bureau of Narcotics and Dangerous Drugs	\$ _____
f. Office of Economic Opportunity	\$ _____
g. Other (specify): _____	\$ _____

60. How is information on drugs usually presented in schools? (Check all applicable)

- 25 a. Standardized curricula
- 22 b. Assemblies
- 30 c. Lectures by experts
- 32 d. Films and audiovisuals
- 17 e. Student initiated research
- 31 f. Group discussions
- 15 g. Field trips
- 32 h. Left to the discretion of the individual school system
- 7 i. Other (specify): _____

61. Who within the individual school system has responsibility for programming and administering drug education courses? (Check all applicable)
- 26 a. Classroom teacher
 - 17 b. Biology teacher
 - 26 c. Health or physical education teacher
 - 18 d. Guidance counselor
 - 23 e. Program is integrated; each instructor is responsible for relating course of study to drug abuse
62. Are teachers who are responsible for drug education courses trained?YES () NO ()
- If "YES,"
- a. Who finances the training? _____
 - b. How long is the initial training period? (State in weeks) _____
 - c. How often are refresher courses required? _____
63. Do students actively participate in formulating drug related school policies and educational programming?YES (22) NO (11)
64. At what grade level is drug related curriculum normally introduced? .. _____
65. What is the average number of hours per week per student devoted to drug related curriculum? (State in hours) _____
66. What sources are utilized for course materials? (Check all applicable)
- 34 a. State Department of Education
 - 29 b. Private publisher
 - 27 c. Teachers develop their own
 - 23 d. Commercial firm
 - 18 e. Another local or state school system
 - 35 f. Federal Government (Specify agency): _____
 - 4 g. Other (Specify): _____
67. Are course materials modified for minority students?YES (11) NO (22)
68. Does the state mandate or recommend that guidance counselors be trained and available to students for individual consultation about drugs? (Check one)
- 0 1. Mandate
 - 17 2. Recommend
 - 20 3. Local option
69. If guidance counselors are trained to be available to students for individual consultation about drugs, please indicate:
- 1. Where they are trained. _____
 - 2. How long the initial training period is (state in weeks) _____
 - 3. How often refresher courses are required. _____
 - 4. What the ratio of counselor to students is _____ to _____
 - 5. The number of hours per week each counselor is available for drug consultation (state in hours) _____



- 6. Are counselors allowed to extend the privilege of confidentiality to students?YES (10) NO (16)
- 7. Do counselors normally make referrals in acute cases?YES (30) NO (1)

70. What is the usual high school action regarding a student in the following situations?

	No action	Suspension	Dismissal	Informing parents	Referral for treatment	Referral to police
Possessing marijuana.._____	_____	_____	_____	_____	_____	_____
Selling marijuana....._____	_____	_____	_____	_____	_____	_____
Possessing heroin....._____	_____	_____	_____	_____	_____	_____
Selling heroin....._____	_____	_____	_____	_____	_____	_____

71. Are there education/training courses offered to adult groups?YES () NO ()

If "YES,"

1. To which groups are these courses offered? (Check all applicable)

- 28 a. Police
- 33 b. Parents
- 30 c. School administrators
- 23 d. Politicians
- 25 e. Businessmen
- 29 f. Civic groups
- 32 g. All interested groups

2. Are these courses provided by the school system?YES (18) NO (18)

72. Are there education/prevention programs outside the public school system?YES (40) NO (0)

If "YES,"

1. Who conducts the programs? _____

2. Does the state fund them?YES (24) NO (16)

3. Are they "outreach" oriented?YES (30) NO (10)

4. Do they receive cooperation from the public school system?YES (37) NO (3)

73. Does the state provide training programs for its own employees engaged in drug abuse programs?YES (26) NO (14)

74. Does the state provide training programs for its own employees in community based programs?YES (25) NO (14)

75. Are any such training programs in operation under any one else's auspices?YES (26) NO (13)

76. Does the state agency have a formal liaison with such training programs?YES (24) NO (12)

77. Are these programs evaluated?YES (20) NO (17)

F. LAW ENFORCEMENT

78. Is your single state agency a member of your state's criminal justice planning agency?YES (15) NO (23)

79. Is there a special narcotics unit within the state police force?YES (32) NO (8)
If "YES,"

1. In what year was this unit established? 19____ 63-

2. Who is the head of this division and what is his address?

Name: _____
Title: _____
Address: _____

ZIP _____

80. What is the annual budget for this division for the last fiscal year? \$ _____

81. How many officers are assigned to the narcotics division full-time? .. _____

82. How many patrolmen are assigned to the narcotics division full-time?.. _____

83. Please complete the following chart regarding arrests and convictions for sale and possession in your jurisdiction during the past 12 months.

	<u>Sale of heroin</u>	<u>Possession of heroin</u>	<u>Sale of marijuana</u>	<u>Possession of marijuana</u>
a. Number of arrests during past 12 months	_____	_____	_____	_____
b. Number arrested but directed to treatment before prosecution	_____	_____	_____	_____
c. Number of prosecutions	_____	_____	_____	_____
d. Number of convictions	_____	_____	_____	_____
e. What was the average duration of sentence?	_____	_____	_____	_____
f. Maximum sentence given during the past 12 months	_____	_____	_____	_____
g. Within the state how many people are presently incarcerated for	_____	_____	_____	_____

84. What treatment options are available to an addict prior to conviction of a crime within your state? _____



85. How long does it presently take from the time of arrest in a heroin possession or sale case to the time of trial? (State in months) _____
86. What percentage of the heroin possession and sale cases are resolved through "plea bargaining?" _____ %
87. How much heroin was confiscated within your jurisdiction during the past 12 months? _____ lbs
88. How much marijuana was confiscated within your jurisdiction during the past 12 months? _____ lbs
89. Is your state police force currently participating in any intergovernmental or interjurisdictional agreements related to narcotics law enforcement? YES (24) NO (8)
- If "YES," please describe briefly. _____

G. TECHNICAL ASSISTANCE

90. Public Law 92-255 requires the federal government to make available a program of technical assistance to the states and localities. The National Association, among others, offers such service programs. Please record the areas in which you would like technical assistance.
- 27 a. Developing the state master plan.
 - 16 b. Developing appropriate state legislation to comply with 92-255.
 - 14 c. Developing a system of coordinating state administration functions.
 - 16 d. Preparation of federal grant proposals.
 - 19 e. Developing and establishing a licensing system.
 - 11 f. Developing and operating programs within your criminal justice system.
 - 12 g. Establishing a civil commitment program.
 - 15 h. Developing education/prevention programs.
 - 19 i. Developing and operating a training program.
 - 5 j. Conducting statewide conferences on drug abuse.
 - 16 k. Developing a program for local physicians.
 - 23 l. Establishing programs to assist business and industry.
 - 10 m. Creating and publishing educational materials.
 - 16 n. Developing vocational rehabilitation and manpower programs.
 - 11 o. Developing treatment/rehabilitation programs.
 - 22 p. Developing and operating a uniform data system.
 - 17 q. Surveying drug abuse among labor force.
 - 11 r. Surveying the distribution of health and other resources.
 - 24 s. Surveying the incidence and prevalence of drug abuse.
 - 21 t. Evaluating school/community education and prevention programs.
 - 21 u. Evaluating treatment/rehabilitation programs.
 - 13 v. Establishing a state research unit.
 - 9 w. Establishing a laboratory system for urinalysis and biochemical research.
 - 10 x. Establishing a system of coordinating local programs.
 - 13 y. Developing a system for community involvement, participation in, and support of local programs.
 - 13 z. Developing proposals for community assistance.

91. Have you planned the expenditure of your state planning grant to be made available under 92-255?YES (19) NO (19)

If "YES," for what purposes? _____

92. Is your state willing to pay for technical assistance from your planning grant funds?YES (30) NO (3)

93. Are there supplemental funds that can also be used to pay for technical assistance?YES (8) NO (26)

H. GENERAL COMMENTS

Please fee' free to offer any general comments you may wish. Areas of interest might include but are not limited to:

- a. Level of satisfaction with your state's response to the drug abuse problem.
- b. Areas of response most in need of improvement.
- c. Restraints (physical, legal, social, economic) preventing you from more effectively responding.
- d. Suggestions for future activities for the federal government, the Drug Abuse Council, the International City Management Association, or the National Association of State Drug Abuse Program Coordinators.

Name: _____ Title: _____

THANK YOU!

APPENDIX C:

LIST OF STATES RESPONDING

(N=41)

Alaska
Arizona
California
Colorado
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
Ohio
Oklahoma
Pennsylvania
Puerto Rico
South Carolina
Tennessee
Texas
Utah
Vermont
Washington
West Virginia
Wisconsin

APPENDIX D:

LIST OF STATES RESPONDING BY SIZE

Of The 10 Largest States:

(N=10)

California
Florida
Illinois
Massachusetts
Michigan
New Jersey
New York
Ohio
Pennsylvania
Texas

*Of The 10 Smallest States:**

(N=7)

Alaska
Delaware
Idaho
Montana
Nevada
New Hampshire
Vermont

* Exclusive of American Samoa, Guam, the Virgin Islands and the Pacific Trust Territories.

Of The 30 Middle Sized States:

(N=24)

Arizona
Colorado
District of Columbia
Georgia
Hawaii
Indiana
Iowa
Kentucky
Louisiana
Maine
Maryland
Minnesota
Missouri
Nebraska
New Mexico
North Carolina
Oklahoma
Puerto Rico
South Carolina
Tennessee
Utah
Washington
West Virginia
Wisconsin

APPENDIX E:

LIST OF STATES RESPONDING BY REGION

Northeast:

(N=7)

Maine
Massachusetts
New Hampshire
New Jersey
New York
Pennsylvania
Vermont

North Central:

(N=9)

Illinois
Indiana
Iowa
Michigan
Minnesota
Missouri
Nebraska
Ohio
Wisconsin

South:

(N=14)

Delaware
District of Columbia
Florida
Georgia
Kentucky
Louisiana
Maryland
North Carolina
Oklahoma
Puerto Rico
South Carolina
Tennessee
Texas
West Virginia

West:

(N=11)

Alaska
Arizona
California
Colorado
Hawaii
Idaho
Montana
Nevada
New Mexico
Utah
Washington

APPENDIX F:

LIST OF STATES NOT RESPONDING BY SIZE AND REGION

	<i>Large</i>	<i>Middle</i>	<i>Small</i>
<i>Northeast</i>		Connecticut Rhode Island	
<i>North Central</i>		Kansas	North Dakota South Dakota
<i>South</i>		Alabama Arkansas Mississippi Virginia	
<i>West</i>		Oregon	Wyoming

OTHERS: American Samoa, Guam, Pacific Trust
Territories, Virgin Islands

THE DRUG ABUSE COUNCIL PUBLICATIONS

The Publications Series of The Drug Abuse Council is offered as an informational service to organizations and individuals engaged in formulating and assessing public policies, operating programs and conducting research related to the nonmedical use of drugs in our society.

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PUBLIC POLICY SERIES

- **A Perspective on "Get Tough" Drug Control Laws**

A Drug Abuse Council staff report analyzing the effects of stringent criminal sanctions on drug abuse and crime. The futility of over-reliance on the criminal justice system to solve the complex problems of drug abuse is examined from historical and legal perspectives.

- **Assessment of the Psychotropic Convention**

Arguments for and against U.S. ratification of the Convention treaty are presented in this Drug Abuse Council staff paper. Analysis includes implications for future national drug legislation.

- **Confidentiality: A Handbook for Drug Treatment Programs**

Designed for drug treatment program operators, this reference guide provides an analysis of Federal laws and regulations covering the confidentiality of drug abuse patient records. Included are the rights and obligations of programs confronted with requests for patient information.

- **Heroin Maintenance: The Issues**

A Drug Abuse Council staff analysis of this controversial subject includes discussion of general concepts, public policy options, specific modalities and anticipated problems. The Vera Institute of Justice proposal for experiments using heroin as inducement to treatment provides a case study.

MONOGRAPH SERIES

- **A Pilot Study of Occasional Heroin Users**

A report on the psychological testing of 12 non-addicted heroin users. This reprint of an article published in the Archives of General Psychiatry is free of charge.

- **Employment and Addiction: Overview of Issues**

New York City was the focal point for this investigation of addiction and employment-related issues. It explores employers' methods of relating to drug users and treatment programs' relationships with employment groups. Recommendations for further study and action are provided.

- **Heroin Epidemics: A Quantitative Study of Current Empirical Data**

One explanation of the spread of heroin use is provided through the application of mathematical models. The study provides a frame of reference for public policy analysis.

- **Methadone Maintenance: The Experience of Four Programs**

Written for The Drug Abuse Council by journalist Paul Danaceau, this study is a descriptive analysis of the treatment process in clinics in New York City, Albuquerque, East Boston and New Orleans, highlighting common issues, problems and needs.

- **Public Administration of Drug Programs ***

Graham S. Finney recounts his experiences as former commissioner of New York City's Addiction Services Agency in this report. A useful primer for program administrators, operators and persons interested in public decision-making, the lengthy study includes chapters on planning, program linkages, intergovernmental relations, uses of technology and the "numbers game."

- **Survey of City/County Drug Abuse Activities/1972 ***

A companion to the State Survey, this report describes drug abuse activities in cities and counties with populations exceeding 50,000 and 100,000 respectively. The study analyzes efforts in law enforcement, administration, education, treatment and rehabilitation.

- **Survey of State Drug Abuse Activities/1972**

An analysis of state drug abuse activities including objectives, priorities and needs as reported by state drug abuse officials during 1972. Designed to yield general information on state efforts, the survey was conducted with the International City Management Association and National Association of State Drug Abuse Program Coordinators. Included are analyses by state size and geographic region.

- **The Organization of the United Nations to Deal With Drug Abuse**

The origins of international drug controls and structure of the United Nations system form the background for this detailed study. Provided are analyses and summaries of core components of the United Nations including the Commission on Narcotic Drugs, Division of Narcotic Drugs, United Nations Fund for Drug Abuse Control, International Narcotics Control Board and World Health Organization.

- **The Retail Price of Heroin: Estimation and Applications**

This summary of research designed to develop estimates of heroin retail prices in selected U.S. cities is applied to problems associated with illicit narcotics use. Extensions of the analysis to other policy-related questions including the effectiveness of law enforcement policies are discussed.

HANDBOOK SERIES

- **Accountability in Drug Education: A Model for Evaluation ***

Designed for use by educators, administrators and researchers, this manual provides step-by-step explanations of program planning and assessment, keyed to the reader's level of involvement. Arranged in "workbook" fashion are sections discussing goal selection and outcome measurement, including a compilation of recommended knowledge, attitude and behavior scales. Other sections provide useful information on the problems of test administration, considerations for scoring tests, and advice about using results to design more effective programs.

- **Community Guide for Drug Program Assessment ***

This study prepared for The Drug Abuse Council by the Urban Institute describes how community leaders can obtain systematic information of local drug programs' effectiveness, relating this to the planning process.

- **High School Student Drug Education Research Project ***

Nine student groups from across the country investigated illicit drug use in their local areas. Their findings and recommendations are detailed in this report. Problems encountered by the student researchers are also described.

BOOKS

- **Army Drug Abuse Program: A Future Model?**

This follow-up study to FEDERAL DRUG ABUSE PROGRAMS focuses on one Federal agency's drug abuse efforts. The feasibility of replicating the military model is discussed. \$2.

- **Dealing With Drug Abuse: A Report to the Ford Foundation**

Published in 1972, by Praeger, Inc., this account of the two year survey project led to the formation of The Drug Abuse Council. Original findings, conclusions and recommendations are included. Background papers discuss treatment modalities, drug education, economics of heroin, drugs and their effects, altered states of consciousness, Federal drug abuse expenditures and the British drug control system. Available at your local bookstore.

- **Federal Drug Abuse Programs**

A report to the American Bar Association and The Drug Abuse Council describing Federal drug abuse activities through July 1972. Analysis and recommendations regarding policies and programs are included. \$15.

* Available after June 1, 1973.



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